of Convulsions and Use of Antipyretics

MORBIDITY AND MORTALITY WEEKLY REPORT 282 Organic Solvents in the Workplace

273 Trends in Human Immunodeficiency Virus Infection Among Civilian

Applicants for Military Service -United States, October 1985-December 1986 281 Pertussis Immunization; Family History

- Supplementary ACIP Statement

Epidemiologic Notes and Reports

Trends in Human Immunodeficiency Virus Infection Among Civilian Applicants for Military Service -United States, October 1985-December 1986

Since October 1985, the U.S. Department of Defense has routinely tested civilian applicants for serologic evidence of infection with human immunodeficiency virus (HIV) as part of their preinduction medical evaluation (1). Results from the first 6 months of testing have been reported previously (2.3). Results for the first 15 months provide the opportunity to observe trends of infection in this population.

Between October 1985 and December 1986, 789,578 civilian applicants for military service were screened. Of these, 1,186 were confirmed as HIV-antibody positive by enzyme immunoassay and Western blot immunoelectrophoresis, for an overall rate of 1.5/1,000 individuals tested. Seroprevalence per 1,000 varied by age, sex, race and ethnicity, and region of residence. By age, it was 0.6 for 17-20 year-olds, 2.5 for 21-25 year-olds, and 4.1 for those ≥ 26 years of age. By sex. it was 1.6 for males and 0.6 for females. By race and ethnicity. seroprevalence per 1,000 was 0.8 for whites, 4.1 for blacks, 2.3 for Hispanics, 1.0 for American Indians or Alaskan Natives and Asian or Pacific Islanders. Table 1 shows the seroprevalence among civilian applicants by region of residence.

TABLE 1. Prevalence of HIV antibody* among civilian applicants for military service, by age group and region of residence - October 1985-December 1986

		Age Group (Years)		
Region [†]	17-20	21-25	≥26	All Ages
New England	0.4	1.0	3.8	0.9
Middle Atlantic	0.7	4.6	10.0	2.9
EN Central	0.4	1.8	1.9	0.9
WN Central	0.2	1.0	1.8	0.6
South Atlantic	0.9	3.4	5.4	2.1
ES Central	0.4	1.9	1.3	0.9
WS Central	0.6	2.7	3.0	1.6
Mountain	0.3	1.5	1.9	0.9
Pacific	0.8	1.5	4.0	1.5
US Territories	1.6	6.3	12.3	5.8
All Regions	0.6	2.5	4.1	1.5

^{*}Repeatedly reactive enzyme-linked immunosorbent assay (ELISA) test confirmed by Western blot immunoelectrophoresis; reported as the number of antibody-positive applicants per 1,000 tested.

[†]Defined in notifiable diseases table (Table III).

HIV Infection - Continued

During the 15-month observation period, the seroprevalence did not change significantly, either in the aggregate or when analyzed by age, sex, race and ethnicity (Figure 1), or geographic region. However, seroprevalence among white males showed a small but significant decline of 0.02/1,000 applicants tested per month (p = 0.016 by Chi Square test for trends in proportions using a logistic regression linear model).

Reported by: Health Studies Task Force, Office of the Assistant Secretary of Defense (Health Affairs), US Dept of Defense, Washington, DC. Div of Preventive Medicine and Div of Communicable Diseases and Immunology, Walter Read Army Institute of Research, Washington, DC. Surveillance and Evaluation Br, AIDS Program, Center for Infectious Diseases, CDC.

Editorial Note: AIDS cases reported to CDC continue to increase*. However, because of the lengthy incubation period of AIDS (4), these cases represent infection occurring at least several years prior to the report of disease. There has been little information to indicate current trends in HIV infection. Analysis of the results of the testing of civilian applicants thus far basically shows neither an increase nor a decrease in infection level for the group as a whole or for individual subgroups. The significance of this apparent absence of change in antibody prevalence during the 15-month period studied is not yet clear.

Volunteers for military service, who are verbally screened by the recruiting official prior to arrival at the medical evaluation center, are not fully representative of the overall population in that they underrepresent the three groups in the United States with the highest prevalence of HIV infection[†]. Moreover, applicants do not equally represent all socioeconomic and demographic groups in the population. A growing awareness of the military serologic screening program may have increased self-deferral by persons who are HIV-antibody positive or who feel they may have been exposed to the virus. If so, this could have masked an increased frequency of infection in the population from which the applicants are drawn.

Monitoring trends in infection among civilian applicants for military service as well as among blood donors remains important. It is also critical to compare trends in infection among these volunteer groups with similar trends among groups not affected by self-selection bias. One such surveillance approach, in which anonymously tested sample populations without AIDS-like disease are monitored at participating hospitals, has been initiated recently by CDC. Trends in exposure risks among seropositive individuals should also be monitored to assess possible changes in the relative frequency of the various modes of transmission. Follow-up interviews of a small number of seropositive applicants have found a high proportion with typical risk exposures for AIDS (5). CDC is collaborating with the U.S. Department of Defense, the National Cancer Institute of the National Institutes of Health, and certain state and local health departments to develop a systematic follow-up evaluation of seropositive civilian applicants in selected cities and states.

References

- Herbold JR. AIDS policy development within the Department of Defense. Milit Med 1986;151:623-7.
- CDC. Human T-lymphotropic virus type III/lymphadenopathy-associated virus antibody prevalence in U.S. military recruit applicants. MMWR 1986;35:421-4.
- Burke DS, Brundage JF, Bernier W, et al. Demography of HIV infections among civilian applicants for military service in four counties in New York City: a preliminary analysis. New York State Med J [In press].

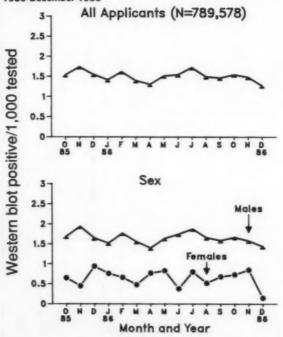
^{*}An average of 38.3 AIDS cases per day were reported for the period October-December 1986, compared with an average of 26.3 per day for the period October-December 1985.

[†]Active intravenous drug abusers, homosexual men, and hemophiliacs.

[§]Long-term data are not yet available for this group.

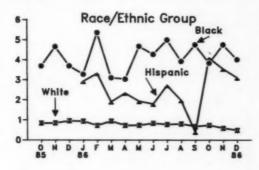


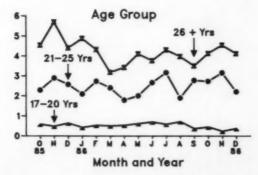
FIGURE 1. Human immunodeficiency virus antibody among civ 1985-December 1986



*U.S. Department of Defense data.

Vol. 36/No. 18





HIV Infection - Continued

- Lui KJ, Lawrence DN, Morgan WM, Peterman TA, Haverkos HW, Bregman DJ. A model-based approach for estimating the mean incubation period of transfusion-associated acquired immunodeficiency syndrome. Proc Natl Acad Sci 1986;83:3051-5.
- Stoneburner RL, Chiasson MA, Solomon K, Rosenthal S. Risk factors in military recruits positive for HIV antibody [Letter]. N Engl J Med 1986;315:1355.

TABLE I. Summary - cases specified notifiable diseases, United States

	18	th Week End	ing	Cumulativ	e, 18th Week	Ending
Disease	May 9, 1987	May 3, 1986	Median 1982-1986	May 9, 1987	May 3, 1986	Median 1982-1986
Acquired Immunodeficiency Syndrome (AIDS)	303	203	N	6.494	4,307	N
Aseptic meningitis	75	67	75	1.515	1,497	1,406
Encephalitis: Primary (arthropod-borne		-				
& unspec)	13	6	18	262	271	318
Post-infectious Post-infectious	1	4	3	20	37	35
Gonorrhea: Civilian	12,549	14,517	15,686	268,252	287,371	287,371
Military	364	149	384	5,905	5,255	7,376
Hepstitis: Type A	439	300	370	8,444	7.619	7,619
Type B	439	493	468	8,540	8,688	8,450
Non A, Non B	53	61	N	1,028	1,179	N
Unspecified	60	88	114	1,144	1,705	1,812
Legionellosis	7	6	N	250	205	N
Leprosy	-	7	7	72	101	97
Malaria	9	18	18	226	249	247
Measles: Total®	142	215	81	1,276	2,526	1,084
Indigenous	133	188	94	1,100	2,426	B
Imported	9	27	N	176	96	R
Maningococcal infections: Total	38	52	58	1,208	1,139	1,209
Civilian	38	52	58	1,207	1,137	1,198
Military				1	2	4
Mumps	349	75	91	6,665	1,227	1,445
Pertussis	12	47	40	584	882	618
Rubella (German measles)	12	4	22	118	177	257
Syphilia (Primary & Secondary): Civilian	531	545	545	11,219	8,914	9,811
Military	1		4	68	79	117
Toxic Shock syndrome	1	2	N	104	123	
Tuberculosis	327	459	441	6 720	6,790	6,96
Tularemia	1		4	35	21	33
Typhoid Fever	10	6	6	94	81	111
Typhus fever, tick-borne (RMSF)	7	3	15	28	30	50
Rabies, animal	100	132	132	1,664	1,906	1,900

TABLE II. Notifiable diseases of low frequency, United States

	Cum. 1987		Cum. 1987
Anthrax		Leptospirosis	8
Botulism: Foodborne (Ohio 1; Calif. 1)	3	Plaque	2
Infant	18	Poliomyelitis, Paralytic	
Other		Psittacosis (Maine 1)	27
Brucellosis (Ohio 1: Tex. 1)	28	Rabies, human	
Cholera	1 .	Tetanus	9
Congenital rubella syndrome	3	Trichinosis	11
Congenital syphilis, ages < 1 year		Typhus fever, flee-borne (endemic, murine)	11
Diphtheria	1 1	(N. Y. City 1)	

Five of the 142 reported cases for this week were imported from a foreign country or can be directly traceable to a known internationally imported case within two generations.

TABLE III. Cases of specified notifiable diseases, United States, weeks ending May 9, 1987 and May 3, 1986 (18th Week)

	AIDS	Aseptic Menin-	Encep	halitis	Genor	rhea	He	patitis (V	irall, by typ		Legionel-	
Reporting Area		gitis	Primary	Post-in- fectious	(Civil		, A	8	NA,NB	Unspeci- fied	losis	Leprosy
	Cum 1987	1987	Cum 1987	Cum 1987	Cum 1987	Cum 1986	1987	1987	1987	1987	1987	Cum 1987
UNITED STATES	6,494	75	262	20	268,252	287,371	439	439	53	80	7	72
EW ENGLAND	236	2	12	1	9,367	6,049	5	40	1	4		4
Asine I H	11	*	1		282	334		1	1	*	*	
/1	6		2		160	176 95	*	4		-	*	2
Mass	131		5		3,478	2.659	3	28	-	3		2
11	21		3	1	753	623	-	-				
Conn	63	2	1		4,626	2,162	2	7	*	1		
WID ATLANTIC	2,028	7	28	1	43,691	48,774	21	33	3	4	*	6
Upstate N Y N Y City	261 1,197	3	15	1	5,708 23,162	5,499 28,402	17	12	3	3	*	5
NJ CHY	417	1	4		5,494	6,505	1	12		1		9
Pa	153		5		9,327	8,368						
N CENTRAL	419	4	64		32,076	39,239	27	51	7	3	3	1
Ohio	71	1	26		8,530	8,980	9	15	3	1	2	1
nd	32		3	-	3,304	4,582	1	6				
III Mich	199	1	8	*	4,659	9,874	4	8	2			
Wis	82 35	2	23	-	12,510	11,536 4,267	13	22	2	2	1	2
WN CENTRAL	136	4	15	*	11,047	12,339	16	7	2			
Minn Iowa	40		9		1,840	1,865	5 2	1				
Mo	67	1			5,554	6,158		4	1			
N Dak	1				103	108						
S Dak	1	1	-	*	220	246			-			
Nebr Kans	7 15	2	3 2		1,616	1,841	9	2	1			
S ATLANTIC	1,063	15	36	8	72,275	72,762	41	103		22	1	4
Del	8		1		1,081	1,170		. 1				
Md D C	141	2	3	2	8,802 4,916	8,806 5,561	4 2	16	1	2		2
Va	142	1	15	1	5,477	6.074	17	9	1	18		
W Va	7		5		547	850		2				
NC	37				10,968	11,878	1	9	2		*	
S C Ga	159			*	5,994 12,358	6,392 12,445	6	30	i		1	1
Fla	471		4	8	22,132	19,786	11	27	3	2		1
ES CENTRAL	64		16	3	20,273	23,645	10	41	4	1		
Ky	17			1	2,055	2,778	2	9			*	
Tenn	37		3		6,974	9,272		16	3			
Ala Miss	8		5	2	4,654	4,965		10	1	1		
W S CENTRAL	593	1 15	28	2	31,604	34,972	35	58	4	0		
Ark	16			1	3,119	3,348	6	2	1			
La	86		5		5,891	6,242	2	23	1		*	
Okla Tex	470	5 8	14	1	3,409 19,185	4,012	25	7 26	2	6		
				1	1-41	8,710	51	18		2		
MOUNTAIN Mont	149	4			7,206	239	2	4				
Idaho	2				255	280	3	4		,		
Wyo	- 3				112	201	:	ā	i			
Colo N Mex	73		1		1,464 794	2,338	2	1	1	1		
Anz	21			1	2.637	2,910	36		6		2	
Utah	1			-	237	372	4	1				
Nev	24	1	-	*	1,529	1,463	1	4	1	1		
PACIFIC	1,80	8 22	55	4	40,714	40,881	233	88	16	18		5
Wash	81	B 1			2,862	3,299	38	12	3			
Oreg	3			:	1,549	1,636	132	14	7	1		4
Calif Alaska	1,63	9 17 5 2		4	35,280 667	1,068	132	1	2	1		
Hawaii	3				356	458	2	1	-			
Guam		-		-	70	34						
PR	1			1	794 82	783	1	12				
Pal: Trust Terr				1	175	66						3
But Tours Tour								1				

TABLE III. (Cont'd.) Cases of specified notifiable diseases, United States, weeks ending May 9, 1987 and May 3, 1986 (18th Week)

Reporting Area			Mea	sies (Rut	eola)		Menin-								
	Malaria	Indig	Indigenous		rted *	Total	gococcal Infections	Mu	mps		Pertusais			Rubella	
	Cum. 1987	1987	Cum 1987	1987	Cum. 1987	Cum. 1986	Cum 1987	1987	Cum. 1987	1987	Cum. 1987	Cum 1986	1987	Cum 1987	Cum 1986
UNITED STATES	226	133	1,100	9	176	2,526	1,208	349	6,665	12	584	882	12	118	177
NEW ENGLAND	15	1	58	5	58	16	120		16	1	16	45			1
Maine N H		*	3	*		*	6		*		*	2		-	
VI.		-	49	3 1	46		13	-	6		2	17		-	1
Mass.		1	1	2 1	4	15	57		2	1	3	2 9	-		
R.I.	4			-		1	11		2			1			
Conn.	3	-	4	*	-	*	26		5		7	14	-		
MID ATLANTIC	14	12	149		35	873	76	13	108	3	82	87	2	5	25
Upstate N Y	9 2	10	9		8	10	52	8	46	3	65	61	2	3	17
N.Y. City N.J.	1	10	116	*	8 2	149 713	8	5	-			3	*	1	
Pa.	2	2	18		17	1	16		33		13	18		1	3
f M. OFMERS					-										
EN CENTRAL Ohio	5	4	104		16	482	160	188	3,834	2	75	162	1	18	10
Ind	-			-	*		59 20	15	46	-	25	63			
000	1	3	60		11	285	23	119	1,948	-	5	16	i	17	7
Mich	*	-	23				48	51	532	2	24	17		11	1
Wis.		*	20		1	193	10	2	827		20	45			-
W.N. CENTRAL	6		34	1.	6	118	61	33	815	1	34	42		1	
Minn.	3		*	18	4	14	18	7	499		7	20		-	
lowa Mo	2	-	34	-	i	5	17	20	232	*	3	6	*	1	
N. Dak	-		34		1	7	17		13	-	13	4 2			1
S Dak		-			-		i	5	38	-	2	3	-	-	
Nebr.		-	-	-			2		2	-	-	1			
Kans		*		-	1	91	19	1	28	1	8	6		-	1
S. ATLANTIC	40	5	42	2	4	350	217	45	118	2	131	343		9	
Del	1			-		1	4	-			131	204			
Md. D.C	8				+	21	18	1	9		2	44		2	
Va	6			-	1	28	5							-	
W. Va			-	-		28	37	40	48	i	33	9		1	
N.C.	5					-	29		2	1	53	14	-	*	
S C	3	*		-		285	20	1	10			4		-	
Ga Flo	2 9	5	42	21	3	12	43 61	2	6 26	-	13	47	*	1	
	1	1		-	-			-				17		5	1
ES CENTRAL			2	-		9	61	43	971		7	16		2	1
Tenn						1	22	33	756		1	5	*	2	1
Ala		-				-	23		13		3	10		-	
Miss	1	1	2		*	*	6	*			2		-		
W.S. CENTRAL	14		74		1	327	91	14	508		40	26			-
Ark	1					274			203		2	20		1	36
La		-			*		10	7	178		9	3			
Okle. Tex.	10		74		1	49	14 59	N 7	127	-	29	21	*	*	
				-	-						*	-			38
MOUNTAIN Mont		29 26	180	1	12	150	45	4	128	-	44	87		6	
Idaho	1	20	42		1	1	3	-	2	-	12	26	*	í	
Wyo								-			2	26		1	
Colo	8			100		6	15		22	*	17	16			
N. Mex.	á	3	137		9	18	3	N	H	-	3	9	*	*	
Ariz Utah	7	-	1		1	126	16	4	97	-	8	23		-	1
Nev.	2			11	1		3	- 2	2	-	1	9		4	
PACIFIC	123	81	457		44	209	000			_					
Wash	7	-	1		44	43	377 50	9	167	3 2	155	74 26	9	76	9
Oreg.	3		2		32	2	14	N	N		13	5		1	
Calif.	110	81	454	*		144	307	8	124		70	40	2	60	9
Aleska Hawaii	3			2	à	20	4 2	i	11	î	46	1	i		
					-						40	2		15	
Guern P.R		46	386	-		3 8	3 2	2	3		11	:	1	1	
VI			-					1	5		11	4		1	5
Pac. Trust Terr.							1	1	3		1			1	
Amer Samoa	*			*					3						

^{*}For measies only, imported cases includes both out-of-state and international importations. N Not notifiable U Unavailable [†]International [§]Out-of-state

TABLE III. (Cont'd.) Cases of specified notifiable diseases, United States, weeks ending May 9, 1987 and May 3, 1986 (18th Week)

Reporting Area	Syphilis (Primary 5.1		Toxic- shock Syndrome	Tuber	culosis	Tule- remia	Typhoid Fever	Typhus Fever (Tick-borne) (RMSF)	Rabies
	Cum 1987	Cum 1986	1987	Cum 1987	Cum. 1986	Cum. 1987	Cum. 1987	Cum 1987	Cum 1987
UNITED STATES	11,219	8,914	1	6,720	6,790	35	94	28	1,864
NEW ENGLAND Maine	171	173	1	194	209		8		
NH	i	11	1	14	19		-		
Vt	1	6		4	7			~	
Mass R I	86	85	-	87	104		6		
Conn	77	12 53	*	21 63	14 56		1		
MID ATLANTIC	2,041	1,207		1,249	1,396				122
Upstate N Y	76	64	*	190	217	-	4		9
N Y City	1,419	671 242		605	674				
Pa	312	230		219 235	251 254		6		110
N CENTRAL	179	371		806	853	1	15		
Ohio	36	45		169	132	i	6	3	47
nd II	18	43		76	104	-	1		6
Wich	44	207		312	380		4	-	22
Wis	20	20	-	220	193	2	2 2		17
N N CENTRAL	50	96	-	193	192	10	7		355
Winn	5 B	16		50	47		2		75
owa Mo	24	49	*	99	16 97	2	2	*	112
V Dak	-	2		1	3	7	3	*	17
Dak	5	1		9	ě				42 76
lebr (ans	5	15	:	11	17	i			12
ATLANTIC	3,868	2,618							21
Del	35	12		1,350	1,311	3	6	8	470
Ad	220	164	-	114	94	1	1	1	170
C /a	122 91	129 154		45	51				21
N Va	5	8		115 43	127	1		*	145
V C	218	188		129	179	1	1	2	22
G C	253 547	246		127	151	-		5	23
is	2,377	1,204	-	200 566	172 473		3		69
S CENTRAL	698	597		546	589	2	1	6	139
(A	6	26		153	153	1			73
enn	293 177	223	-	143 180	160		1	3	38
Aiss	222	142		70	192 84	1		ż	28
VS CENTRAL	1,459	1,814		753	822	10	6	10	240
krik	75	93	-	82	92	3	1	10	65
a Okto	258	303		105	171	1			4
ex	1,072	1,362	:	72 494	74 485		3	10	162
MOUNTAIN	248	222		171	144	7	3	1	133
font	7	2		8	7	1		i	67
saho Vyo	22	1	*	16	5	1			
olo	32	65			7	1		-	35
Mex	21	26	-	36	34	1	3		
ing	121	93	-	95	68	2	-		29
iev	38	31		10	10 13	1			2
ACIFIC	2,505	1,816		1,458	1,274	2	90		
Vash	31	48		74	71	1	39	1	156
reg	94	35		43	45	i			
laska	2,372	1,716		1,247	1.084		37	1	167
awan	5	17		72	17 57	:	2	:	1
uam	2	. 1		4					
R	324	299		86	86				23
ac Trust Terr	83	105		56	10	*			
mer Samoa	2	. 30		00	10		9		-

U Unevailable

TABLE IV. Deaths in 121 U.S. cities," week ending May 9, 1987 (18th Week)

Reporting Area		All Caus	es, By A	ge (Yeer	ra)		P&F* Total Reporting		All Causes, By Age (Years)						
	All Ages	>65	45-64	25-44	1-24	<1		Reporting Area	All Ages	≥65	45-64	25-44	1-24	<1	Tota
NEW ENGLAND	708	506	126	48	15	13	49	S ATLANTIC	1,184	722	276	93	42	51	34
Boston, Mass.	204	141	36	18	4	5	23	Atlanta, Ga	167	86	41	14	6	20	6
Bridgeport, Conn.	58	33	10	11	1	3	2	Baltimore, Md.	192	113	52	21	2	4	4
Cambridge, Mess.	16	15	1	*	-		2	Charlotte, N.C.	113	58 72	17	11	2	6	4
Fall River, Mass. Hartford, Conn.	30 68	23	6	-	1	-	-	Jacksonville, Fla. Miami, Fla.	101	62	22	10	5	2	2
Lowell, Mass.	31	23	11	6 2	2	1	2	Norfolk, Va.	64	36	15	10	5	8	3
Lynn, Mess.	21	19	2	4		-		Richmond, Va.	82	52	24	2	3	1	3
New Bedford, Mas		18	2			2	3	Savannah, Ga.	29	24	3		2		2
New Haven, Conn.		35	7	4	-	-	3	St. Petersburg, Fla.	85	68		3	5	1	2
Providence, R.I.	63	46	10	3	4		5	Tampa, Fla.	81	52	16	7	4	2	
Somerville, Mass.	8	7	1		-	*	1	Washington, D.C.	155	84	45	19	4	3	- 4
Springfield, Mass.	43	33	8	1	-	1	3	Wilmington, Del	21	15	5	*	*	1	
Waterbury, Conn.	33	23	9	1	-	-	2	CO OFWINA	200	470	487	62	17	26	34
Worcester, Mass.	65	42	18	2	2	1	2	E.S. CENTRAL	738 133	476 91	157		1	4	2
MID ATLANTIC	2,667	1.747	551	253	61	55	154	Birmingham, Ala. Chattanooga, Tenn.	47	34	10			1	2
Albeny, N.Y.	56	36	14	4		2	1	Knoxville, Tenn	71	45	14	6	5	1	3
Allentown, Pa.	11	8	3			-		Louisville, Ky	114	80	24		1	2	1
Buffalo, N.Y.	119	89	18	8	1	3	10	Memphis, Tenn	149	92	30		4	13	1
Camden, N.J.	48	30	9	6	2	1	2	Mobile, Ale.	56	32	13		1	2	;
Elizabeth, N.J.	24	17	3	4			1	Montgomery, Ala	44	26	10	5	1	2	
Erie, Pa.1	29	22	4	2		1	2	Nashville, Tenn.	124	76	30	13	4	1	1
Jersey City, N.J.	45	32	. 0	3	1	1	1								
N.Y. City, N.Y.	1,443	916	305	165	35	22	66	W.S. CENTRAL	1,402	854	301	127	59	61	53
Newark, N.J.	30	23	18	2	1	3	2	Austin, Tex.	56	37	11	4	3	1	1
Paterson, N.J. Philadelphia, Pa.	400	257	90	31	12	10	35	Baton Rouge, La Corpus Christi, Tex	59	37	15		3	2	
Pittsburgh, Pa.1	52	30	14	3	1	4	30	Dallas, Tex	197	118	10		17	3	-
Reading, Pa.	28	22	6			-	5	El Paso, Tex	65	30	23		1	8	1
Rochester, N.Y.	100	77	18	4		1	12	Fort Worth, Tex	100	58	19	12	6	5	-
Schenectady, N.Y.	32	25	4		1	2	3	Houston, Tex 6	308	176	74		13	11	3
Scranton, Pa.1	32	28	3	1			4	Little Rock, Ark	75	56	10		2	2	4
Syracuse, N.Y.	84	60	13	7	3	1	4	New Orleans, La	152	81	40	15	3	13	
Trenton, N.J.	41	27	6	3	4	1	1	San Antonio, Tex	174	115	33		4	6	1
Utica, N.Y.	12	10	2	-	*		-	Shreveport, La	64	41	11		3	5	-
Yonkers, N.Y.	28	16	9	2		1	4	Tulsa, Okla	107	76	18		4	4	
E.N. CENTRAL	2.222	1,464	492	151	44	71	93	MOUNTAIN	635	418	133		20	22	
Akron, Ohio	81	58	18	2		3	3	Albuquerque, N Mes	80 49	55 35	17		2	1	1
Canton, Ohio	38	26	8	3		1	2	Colo Springs, Colo	108	70	25		3	7	
Chicago III §	564	362	126	45	10	22	16	Denver, Colo	80	46	29		1	2	
Cincinneti, Ohio Cleveland, Ohio	111	71 81	30	6	6	6	18	Las Vegas, Nev Ogden, Utah	26	15				3	
Columbus, Ohio	127	78	33	9	4	3	1	Phoenix, Ariz	124	78	24			4	
Dayton, Ohio	112	76	32	3	-	1	4	Pueblo, Colo	18	15	1		1		
Detroit, Mich.	238	141	47	37	6	7	8	Salt Lake City, Utah	45	30			3	3	
Evensville Ind.	42	31			2	1	1	Tucson, Arig	105	74	11	9	2	1	
Fort Wayne, Ind.	49	40	6	2		1	3								
Gary, Ind.	13	6	4	1	1	1		PACIFIC	1,882	1,224	387		58	45	10
Grand Rapids, Mic		36	13	2	2	2		Berkeley, Calif.	18	12	3			1	
Indianapolis, Ind.	158	105	26	15	3	9	4	Fresno, Calif	88	63	16	5	3	2	
Medison, Wis.	37	21		3	3	2	3	Glendale, Calif	12	11		:	-	-	
Milwaukee, Wis.	128	93	25	7	2	1	:	Honolulu, Hawaii Long Beach, Calif	62	35 52	18		2	2	
Peorie, III. Rockford, III.	41	29	10	2		3	2	Los Angeles, Calif	541	345	115		22	6	1
South Bend, Ind.	87	58	22	3	2	2	7	Oakland, Calif.	65	41	14		2	3	
Toledo, Ohio	109	87	17	1	1	3		Pasadena, Calif.	22	19	1	1	1		
Youngstown, Ohio		38	10	3		-	1	Portland, Oreg.	157	104	34	10	4	- 4	
	810	525	174	61	25	24	44	Sacramento, Calif.	149	98	27		4 7	6	
W.N. CENTRAL Des Moines, Iowa		45	14	2	1	3	7	San Diego, Calif. San Francisco, Calif.	144	96	31		2	1	
Duluth, Minn.	27	20	5	2		3	2	San Jose, Calif	158	95	36		3	6	
Kansas City, Kans		17	6	4	4	2	2	Seattle, Wash.	139	92	21		7	5	
Kansas City, Mo.	120	90	18	7	3	2	8	Spokane, Wash	54	41				1	
Lincoln, Nebr.	39	30	7	1	1	-	1	Tacome, Wash	41	23	13		1		
Minnespolis, Minr		122	44	12	3	2	2								
Omeha, Nebr.	88	54	20	6	4	4	5	TOTAL	12,248	7,936	2,597	7 1,003	341	368	59
St. Louis, Mo.	125	71	28	13	5	8	14								
St. Paul, Minn.	62	37	14	6	3	2	1	1							
Wichita, Kans.	67	39	18	8	1	1	2								

^{*} Mortality data in this table are voluntarily reported from 121 cities in the United States, most of which have populations of 100,000 or more. A death is reported by the place of its occurrence and by the week that the death certificate was filed. Fetal deaths are not included ** Presumonia and influenza. *

** Because of changes in reporting methods in these 3 Pennsylvania cities, these numbers are partial counts for the current week. Complete counts will be available in 4 to 6 weeks.

**Total includes unknown ages.

**Data not available. Figures are estimates based on average of past 4 weeks.

Recommendation of the Immunization Practices Advisory Committee (ACIP)

Pertussis Immunization; Family History of Convulsions and Use of Antipyretics — Supplementary ACIP Statement

The Immunization Practices Advisory Committee (ACIP) has reviewed available data concerning the risks and benefits of pertussis vaccine for infants and children with a family history of convulsions. Based on this review, the ACIP does not believe that a family history of convulsions should be a contraindication to vaccination with diphtheria and tetanus toxoids and pertussis vaccine (DTP). In addition, the ACIP believes that antipyretic use in conjuction with DTP vaccination may be reasonable in children with personal or family histories of convulsions. Consequently, the following statement updates some of the previous recommendations regarding pertussis vaccine (1).

Vaccination of Children with Family Histories of Convulsions with Pertussis Vaccine

The risk of neurologic events after DTP vaccination is very small. Most neurologic events (primarily febrile seizures, but including nonfebrile seizures, encephalopathy, or other neurologic symptoms) that occasionally follow DTP vaccination occur in children without known risk factors. However, recent studies suggest that infants and children with a history of convulsions in first-degree family members (i.e., siblings and parents) have a 3.2-fold increased risk for neurologic events compared with those without such histories (CDC, unpublished data). Nevertheless, these children are still at very low risk for serious neurologic events following DTP vaccination. Convulsions within 3 days of DTP vaccination may be unrelated to vaccination, induced by vaccine components, or initiated by vaccine-associated fever in those children prone to febrile convulsions. Although children with a family history of seizures have an increased risk for developing idiopathic epilepsy, febrile seizures (including those following vaccinations) do not themselves increase the probability of epilepsy or other neurologic disorders (2,3).

After careful deliberation, the ACIP has concluded that a family history of convulsions in parents and siblings is not a contraindication to pertussis vaccination and that children with such family histories should receive pertussis vaccine according to the recommended schedule (1,4). The committee reached this decision after considering 1) the risks of pertussis disease, 2) the large number of children (5%-7%) with a family history of convulsions, 3) the clustering of these children within families, and 4) the low risk of convulsions following pertussis vaccination (1-3,5).

The ACIP believes that parents of infants and children with family histories of convulsions should be informed of their children's increased risk of seizures following DTP vaccination. In particular, they should be told, before the child is vaccinated, to seek immediate medical evaluation in the unlikely event of a seizure. The child's permanent medical record should document that the small risk of postvaccination seizure and the benefits of pertussis vaccination have been discussed.

Antipyretic Use in Children with Personal or Family Histories of Convulsions

There are no data on whether the prophylactic use of antipyretics following DTP vaccine can decrease the risk of febrile convulsions. However, preliminary information suggests that acetaminophen given at a dose of 15 mg/kg at the time of DTP vaccination and again 4 hours later will reduce the incidence of postvaccination fever (6). Thus, it is reasonable to

Pertussis - Continued

consider administering antipyretics (such as acetaminophen) at age-appropriate doses at the time of vaccination and every 4 to 6 hours for 48 to 72 hours to children at higher risk for seizures than the general population.

References

- ACIP. Diphtheria, tetanus, and pertussis: guidelines for vaccine prophylaxis and other preventive measures. MMWR 1985:34:405-14, 419-26.
- 2. Nelson KB, Ellenberg JH. Prognosis in children with febrile seizures. Pediatrics 1978;61:720-7.
- Hirtz DG, Nelson KB, Ellenberg JH. Seizures following childhood immunizations. J Pediatr 1983; 102:14-8.
- ACIP. New recommended schedule for active immunization of normal infants and children. MMWR 1986;35:577-9.
- Cody CL, Baraff LJ, Cherry JD, Marcy SM, Manclark CD. Nature and rates of adverse reactions associated with DTP and DT immunizations in infants and children. Pediatrics 1981;68:650-60.
- Ipp MM, Gold R, Greenberg S, et al. Acetaminophen prophylaxis of adverse reactions following vaccination of infants with DTP-polio. Pediatr Infect Dis [In press].

Current Trends

Organic Solvents in the Workplace

On March 31, 1987, the National Institute for Occupational Safety and Health (NIOSH) released *Current Intelligence Bulletin #48: Organic Solvent Neurotoxicity*. This is another in a series of NIOSH publications on specific chemical substances, physical agents, or safety hazards found in the workplace. The document, summarized below, is now available to the public*.

Acute exposure to organic solvents can impair manual dexterity, response speed, coordination, or body balance. Epidemiologic studies of workers chronically exposed to organic solvents have demonstrated reduced function of peripheral nerves and increases in the rates of adverse neurobehavioral effects. Such effects include reversible, subjective symptoms (e.g., fatigability, irritability, and memory complaints), sustained changes in personality or mood, and impaired intellectual function (e.g., decreased learning ability, memory, and ability to concentrate). Results of studies involving the chronic exposure of animals to a limited number of organic solvents support the observations of peripheral nervous system dysfunction and neurobehavioral effects in humans.

Approximately 49 million tons of industrial solvents were produced in the United States in 1984. They are used in paints, adhesives, glues, coatings, degreasing/cleaning agents, dyes, polymers, plastics, textiles, printing inks, agricultural products, and pharmaceuticals. An estimated 9.8 million workers in these industries may be exposed to organic solvents by either skin contact or inhalation.

Employers should institute educational programs to inform workers about materials to which they are exposed, potential health risks of such exposure, and safe work practices for

^{*}Copies of CIB #48 can be obtained without charge from the Publications Dissemination Section, Division of Standards Development and Technology Transfer, National Institute for Occupational Safety and Health, 4676 Columbia Parkway, Cincinnati, Ohio 45226; telephone: (513) 841-4287.

Organic Solvents - Continued

handling these materials. Employers should also assess the conditions under which workers may be exposed to organic solvents, develop programs to survey the extent of worker exposure and the effectiveness of existing controls, improve these controls as needed, and consider establishing medical surveillance for the adverse health effects of excess exposure.

As prudent public health policy, NIOSH recommends that employers take all reasonable precautions to reduce exposures at least to the concentrations specified as permissible exposure limits (PELs) by the Occupational Safety and Health Administration or to NIOSH's recommended exposure limits or the American Conference of Governmental Industrial Hygienist's threshold limit values (if the latter two values provide a greater degree of protection). The three basic methods for limiting worker exposures to organic solvents are: 1) using engineering controls such as closed-system operations and exhaust ventilation, 2) isolating workers in closed booths from which they can use automated controls to run external operations, and 3) equipping workers with carefully selected and scrupulously maintained solvent-resistant gloves, aprons, boots, face shields, safety goggles, work suits, and respiratory protection.

Reported by: Div of Standards Development and Technology Transfer, National Institute for Occupational Safety and Health, CDC.

FIGURE I. Reported measles cases - United States, weeks 14-17, 1987



The Morbidity and Mortality Weekly Report is prepared by the Centers for Disease Control, Atlanta, Georgia, and available on a paid subscription basis from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402, (202) 783-3238.

The data in this report are provisional, based on weekly reports to CDC by state health departments. The reporting week concludes at close of business on Friday; compiled data on a national basis are officially released to the public on the succeeding Friday.

The editor welcomes accounts of interesting cases, outbreaks, environmental hazards, or other public health problems of current interest to health officials. Such reports and any other matters pertaining to editorial or other textual considerations should be addressed to: ATTN: Editor, Morbidity and Mortality Weekly Report, Centers for Disease Control, Atlanta, Georgia 30333.

Director, Centers for Disease Control James O. Mason, M.D., Dr.P.H. Director, Epidemiology Program Office

Carl W. Tyler, Jr., M.D.

Editor

Michael B. Gregg, M.D. Managing Editor Gwendolyn A. Ingraham

QU.S. Government Printing Office:1987-730-145/40059 Region IV

DEPARTMENT OF HEALTH & HUMAN SERVICES **Public Health Service** Centers for Disease Control Atlanta GA 30333

Official Business Penalty for Private Use \$300



Postage and Fees Paid U.S. Dept. of H.H.S. HHS 396

A 48106SER 06 8639 SERIALS ACQUISITION DEPT UNIVERSITY MICROFILMS 300 NORTH ZEEB RDAD ANN ARBOR, MI 48106

